

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006935

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 650

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED FEB 18 1963

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>1nday</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheran</b>		d. STREET ADDRESS (If outside, give location) <b>3412 Dover</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maudie</b> Middle <b>Irene</b> Last <b>Rice</b>		4. DATE OF DEATH Month <b>1/30</b> Day <b>1963</b> Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/95</b>
9. AGE (last birthday) <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (City and state or country) <b>Kansas City, Kans.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Mc Donald</b>		13b. MOTHER'S MAIDEN NAME <b>Julia Ferguson</b>	
14. NAME OF HUSBAND OR WIFE <b>Walter V. Rice</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>Walter V. Rice Home</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>REFRACTORY CONGESTIVE HEART FAILURE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		<b>8 YRS</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CHRONIC ATRIAL FIBRILLATION, ANASARCA</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>JULY 1955</b> to <b>30 JAN 63</b> and last saw her alive on <b>30 JAN 1963</b> Death occurred at <b>4:40 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James W. Fowler M.D.</b>		22b. ADDRESS <b>1103 GRAND AVE.</b>	
22c. DATE SIGNED <b>31 JAN 63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2/2/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chapel Hill</b>	
23d. LOCATION (City, town, or county) (State) <b>Wyandotte, Kansas</b>			
24. FUNERAL DIRECTOR ADDRESS <b>R.A. Fulton, Kansas City, Kansas</b>		25. DATE RECD. BY LOCAL REG. <b>1-31-63</b>	
26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF JAMES W. FOWLER

USE BLACK INK  
OR  
TYPEWRITER RIBBON

James W Fowler  
Professional Bldg

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ralph Fulton

Licensed Embalmer No. 3503

P. O. Address K. C. K-2

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.